

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

### **I. DISPUTE**

1. a. Whether there should be reimbursement of \$468.00 for date of service 11/07/01.
- b. The request was received on 01/24/02.

### **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60 and undated Letter Requesting Dispute Resolution
  - b. HCFA(s)-1500
  - c. TWCC 62 forms
  - d. Medical Records
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Response to a Request for Dispute Resolution dated 05/07/02
  - b. TWCC 62 forms
  - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier 04/24/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/25/02. The response from the insurance carrier was received in the Division on 05/08/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

### **III. PARTIES' POSITIONS**

1. Requestor: The requestor states in undated correspondence that, "We received preauthorization for aquatic therapy for the cervical and thoracic spine for which \_\_\_\_ is compensable. If you would read our SOAP notes you will see that these exercises were done to the cervical and thoracic spine. The insurance carrier's pre-authorization department or the review company that they used had already approved the pre-authorization request for treatment."

2. Respondent: The representative for the respondent states in the correspondence dated 05/07/02 that, "In dispute are billings for various physical therapy treatments rendered on 11-7-01. Carrier had denied this [sic] bills as preauthorization was required for these treatments..., but not obtained by the provider prior to rendering the services."

#### **IV. FINDINGS**

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/07/01. One unit of 97113 will be addressed in the Dismissal of this document.
2. The provider billed \$468.00 for date of service 11/07/01.
3. The carrier did not reimburse the provider for any services billed for date of service 11/07/01.
4. The amount in dispute is \$468.00 for date of service 11/07/01.
5. The carrier denied the services billed by denial codes "A – PREAUTHORIZATION REQUIRED BUT NOT REQUESTED ONLY CERVICAL PT WAS PRE AUTHORIZED" and "A – PREAUTHORIZATION REQUIRED BUT NOT REQUESTED." The carrier's response to the request for medical dispute was timely. No other EOB(s) or medical audits are noted. Therefore, the Medical Review Division's decision is rendered based on denial codes submitted to the provider prior to the date of this dispute being filed.
6. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
11/07/01	97113	\$52.00	\$0.00	A -Only Cervical PT was Pre Authorized	\$52.00 per 15 minute	Rule 133.600 (h) (10); CPT descriptor	<p>“The health care treatments and services requiring pre-authorization are:...physical therapy ...beyond eight weeks of treatment.”</p> <p>In the provider’s SOAP notes, references are made to the claimant’s “arms, heels, gluteus maximus, shoulders, hip extensors, abdominals, hamstring muscles, and upper trunk.”</p>
							<p>The provider’s SOAP notes state the claimant’s “...first exercise consisted of three sets of running forward for 2 minutes in chest to neck deep water.”</p> <p>The claimant was told to “stand astride and hold a ball with both hand...keep his arms at 90 degrees with his hands cupped...lean his body forward...rotate the upper trunk...stand with his legs straight and hold onto the handrails while bending his upper trunk...then brought one knee in towards his trunk.” The notes also stated the claimant “extended the opposite arm forwards...bend his knee quickly...stretch the posterior deltoid, teres major, minor, latissimus dorsi, pectoralis major, and triceps.”</p> <p>However, the provider failed to submit medical documentation to support that physical therapy was rendered to the cervical body area only. No reimbursement is recommended.</p>
11/07/01	97113	\$52.00	\$0.00	A	\$52.00 per 15 minute	Rule 133.600 (h) (10); CPT descriptor	<p>“The health care treatments and services requiring pre-authorization are:...physical therapy ...beyond eight weeks of treatment.”</p> <p>The provider stated in the letter requesting medical dispute resolution, “We received preauthorization for aquatic therapy...”, but the provider failed to submit the pre-authorization approval in the request for medical dispute resolution packet, therefore, no reimbursement is recommended.</p>
11/07/01	97113	\$52.00	\$0.00				
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11/07/01	97113	\$52.00	\$0.00				
<b>Totals</b>		\$416.00	\$0.00				The Requestor <b>is not</b> entitled to reimbursement.

The above Findings and Decision are hereby issued this 21st day of May 2002.

Donna M. Myers, B.S.  
Medical Dispute Resolution Officer  
Medical Review Division

DMM/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.

## **VII. Dismissal**

Date of service 11/07/01 CPT code 97113 is being dismissed. According to Commission Rule 133.307 (m), the Division may dismiss a request if "The commission determines that the medical bills in dispute have not been properly submitted to the carrier pursuant to § 133.304...." The provider failed to submit a HCFA for a 15 minute unit of CPT code 97113. This dismissal does not constitute a decision on this date of service.